

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/15/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1/30/12. This visit also included the PSR to the Investigation of Complaint IN00102157 completed on 1/30/12.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaint IN00102899 completed on 1/30/12.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00104672</p> <p>Complaint Number IN00102157-Corrected.</p> <p>Survey Dates: March 14 & 15 2012</p> <p>Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 149 SNF/NF 149 Total</p> <p>Census Payor Type: 21 Medicare 113 Medicaid 15 other 149 Total</p> <p>Sample: 9</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	<p>Continued From page 1</p> <p>Golden Living Center Fountainview Terrace was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2. in regards to Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00102157 completed on 1/30/12.</p> <p>Quality review completed on March 16, 2012 by Bev Faulkner, RN</p>			{F 000}			